

2012 Behavioral Health Finance and Integration

Public Stakeholder Process

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Behavioral Health Integration

- As part of the FY 2012 budget, the General Assembly asked the Department of Health and Mental Hygiene to convene a workgroup and provide recommendations “to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues.”
- After a workgroup process, a Consultant’s Report was published outlining two potential integration models for Maryland

Behavioral Health Integration

- While this report was comprehensive, Secretary Sharfstein felt more work needed to be done before a model could be chosen
- In early 2012, a Steering Committee was selected with representation from:
 - DHMH
 - Office of Health Care Financing
 - Office of Behavioral Health and Disabilities
 - MHA
 - ADAA
- Stakeholder meetings are being held to inform these efforts
- Recommendation to be made by September 30, 2012

Workgroups

- Four workgroups have been created to provide insight into critical areas:
 - Systems Linkage: To make a recommendation on those factors that should be present to promote "integration." For example, should there be a shared electronic health record among all providers within an MCO? What factors indicate “integrated” care, and what factors indicate “collaborative” care?
 - Evaluation and Data: To determine what data is available and relevant to the ultimate recommendation on the model, and to make a recommendation on potential measures to evaluate any selected model.

Workgroups

- State and Local Roles: To make a recommendation on what services/financing should be left outside a “Medicaid” integrated care model to accommodate non-Medicaid eligible populations, or non-Medicaid-eligible services. This Workgroup will also make a recommendation on the roles that state and local government should perform depending on which services/financing are left outside of the Medicaid financing model, as well as how to support and interface with selected model.
- Chronic Health Homes: To make a recommendation on a new “Health Home” service under the Affordable Care Act, and make a recommendation on how the new service could be developed to support any integration model. For example, this workgroup would help define the service; define the population eligible for the service; and define the provider qualifications to deliver the service.

What is *not* being asked of these workgroups?

- The purpose of these workgroups is to provide the behavioral health integration steering committee with expert knowledge on key subjects to inform the committee's deliberations regarding the finance and integration model. The workgroups are *not* charged with making recommendations directly regarding the potential models.

Workgroup Process

- 4-5 meetings from now through late August
- Final report due early September
- Information and materials for all workgroups, including RSVP survey, will be sent out to entire stakeholder group every Friday

Criteria to Select a Model

1. Best ensures delivery of the right service, in the right place, at the right time, by the right practitioner
2. Best ensures positive health outcomes in behavioral health and somatic care using measures that are timely and transparent
3. Best ensures preventive care, including early identification and intervention
4. Best ensures care across an individual's lifespan
5. Best ensures positive consumer engagement
6. Best aligns with treatment for chronic conditions

Criteria to Select a Model

7. Best ensures the delivery of culturally and linguistically competent services that are evidence-based and informed by practice-based evidence
8. Best ensures that the system is adaptable over time, as other payment and delivery system reforms occur, without loss in value or outcomes
9. Best ensures program integrity and cost-effectiveness
10. Best ensures administrative efficiencies at state, local, plan, provider, and consumer/family levels
11. Best ensures seamless transitions as service needs change, and as program eligibility changes

Potential Models

Model 1: Protected Carve-In

Medicaid-financed behavioral health benefits would be managed by Medicaid managed care organizations (MCOs) through a “protected carve-in”. The MCOs would be responsible for managing a comprehensive benefit package of general medical and behavioral services. Contractual conditions would require the MCOs to employ specific behavioral health practitioners in clinical leadership positions, would specify the credentials of staff who performed behavioral health utilization management, and would put the MCOs at risk for demonstrating that they were assuring access to the behavioral health benefit. This model would protect funds spent on behavioral health treatment but would allow the MCOs to have flexibility in how they structured care coordination, utilization management, etc.

Potential Models

Model 2: Risk-Based Carve-Out

Medicaid-financed specialty behavioral health benefits and the State/block grant-funded benefit package would be managed through a risk-based contract with one or more Behavioral Health Organizations (BHO). Contractual conditions would be aligned with those of the Medicaid MCOs; performance standards would be robust and performance risk would be shared with MCOs for continued implementation of health homes for persons with behavioral health conditions, as well as health homes for persons with chronic medical conditions and for improvement in health outcomes for persons enrolled in health homes. The services delivered through the BHO would be specialty behavioral health services. MCOs would continue to provide specified behavioral health care typically associated with primary care providers.

Potential Models

Model 3: Risk-Based Population Carve-Out

As in Model 1, all Medicaid-financed behavioral health benefits and general medical benefits would be delivered under a comprehensive risk-based arrangement. In this model, however, Medicaid would competitively select one or more specialty health plan(s) to manage the comprehensive benefit package for individuals with serious behavioral health diagnoses. If such a diagnosis is present, the person would be enrolled in a specialty health plan, which would be required to deliver the full array of behavioral health and medical benefits. If such a diagnosis is not present, the person would be enrolled in a traditional MCO to receive his/her full array of behavioral health and general medical benefits.

Behavioral Health Post-2014



- Under federal health reform law, all health plans must cover behavioral health services
- Medicaid Expansion makes most adults under 138% FPL eligible for Medicaid
- Beginning Jan 1, 2014, most behavioral health services are likely to shift from grant-funded to being covered by Medicaid or private insurers

As a result, these efforts are to select a finance and integration model for Medicaid-financed behavioral health services only.

BH Integration Website

<http://www.dhmmh.state.md.us/bhd/SitePages/integrationefforts.aspx>

2012 Finance and Integration Options Stakeholder Process

Read a kick-off letter  from Chuck Milligan and the seven guiding principles  put forth by Joshua Sharfstein. To receive e-mail regarding this process, or if you have questions/comments, please write to bhintegration@dhmmh.state.md.us.

- [Submit Comments](#)
- [Meetings Schedule](#)
- [Resources](#)
- [Workgroups](#)

Date, time, location, agenda, and meeting materials for all large group meetings

Date, time, location, agenda, and meeting materials for all workgroup meetings

External documents, web page, and other relevant links

Submitting Comments

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter:

Organization:

Date: [Click here to enter a date.](#)

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment:

E-mail all comments and suggestions to bhintegration@dhmh.state.md.us.

Please specify the ***Related Workgroup(s)*** in the subject of your e-mail, if applicable.

Meetings Schedule

Large BH Integration Group:

- June 5 1:30-3:30pm
- July 9 1:30-3:30pm
- August 14 1:30-3:30pm
- September 11 1:30-3:30pm

Systems Linkage Workgroup*:

- May 10 1:30-3:30pm
- May 31 1:30-3:30pm
- June 28 1:30-3:30pm
- July 26 1:30-3:30pm
- August 23 1:30-3:30pm

Evaluation (Data) Workgroup*:

- May 9 10:00am-12:00pm
- June 6 2:00-3:30pm
- July TBD
- August 8 10:00-11:30am

State/Local and Non-Medicaid Workgroup*:

- May 8 2:30-4:40pm
- June 13 1:30-3:30pm
- July 11 1:00-3:00pm
- August 21 1:00-3:00pm

Chronic Health Homes Workgroup*:

- May 17 12-1:30pm
- June 14 1:30-3:30pm
- July 12 1:30-3:30pm
- August 9 1:30-3:30pm

*Workgroup dates/times subject to change.

Please direct all questions and comments to:
bhintegration@dhmh.state.md.us